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Joint Committee on Finance
100TH ANNIVERSARY 1911 - 2011

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative Robin Vos

Date: September 30, 2011

Re: DHS Report to JFC

Attached is a report on the Medicaid Budget Efficiencies from the Department of Health Services, pursuant to s. 49.45(2m)(f), Stats.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

AD:RV:jm

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

September 30, 2011

The Honorable Alberta Darling, Senate Co-Chair
Joint Committee on Finance
Room 317 East, State Capitol
Madison, WI 53702

The Honorable Robin Vos, Assembly Co-Chair
Joint Committee on Finance
Room 309 East, State Capitol
Madison, WI 53702

Dear Senator Darling and Representative Vos:

As required under the 2011-13 biennial budget, Act 32 s. 49.45(2m)(f), I am writing to provide you an update for the first quarter of FY 12 on the overall condition of the Medicaid benefits budget and the Department's efforts to identify and implement savings measures in the program. In an effort to fully inform the Legislature in a timely way, we are including all our current reform proposals in this report, regardless of whether a state plan amendment or waiver is necessary to obtain federal approval. For those items that conflict with current statutes, the Department will formally submit them to the Joint Committee on Finance under s. 49.45(2m)(d) at a later date after obtaining public input.

Overall Condition of the Medicaid Benefits Budget
Recently, the Department updated its projection for the expenditures and revenues in the Medicaid program in the 2011-13 biennium, based on additional data on caseload, costs per individual, and revenues since Act 32 was enacted. GPR expenditures are projected to be higher than assumed in the budget due to revised projections for drug rebate revenues and higher costs per enrollee in certain areas of the program. These higher costs are partially offset by other favorable expenditure trends in other areas, for a net increase of $38 million GPR. Act 32 directed DHS to identify $444.6 million All Funds ($181.8 million GPR) in additional savings in Medicaid. Based on these updated projections, the Department will need to identify $554.4 million All Funds ($219.5 million GPR) to balance the program in the 2011-13 biennium.

Projected Medicaid Expenditures for the 2011-13 Biennium (in millions)				
	GPR/SEG/PR		All Funds	
	Act 32	September Update	Act 32	September Update
Cost to Continue	$5,665.07	$5,695.67	$14,650.62	$14,741.69
Savings Measures				
Act 32 Targeted Measures	*($123.7)*	*($116.3)*	*($312.41)*	*($293.72)*
Savings target per s. 49.45(2m)	*($181.5)*	*($219.5)*	*($444.6)*	*($554.36)*
Total Savings	*($305.2)*	*($335.8)*	*($757.01)*	*($848.08)*
Budgeted Level	$5,359.87	$5,359.87	$13,893.61	$13,893.61

GPR expenditures in the program are based on numerous factors, including caseload, service utilization, premiums, rebates and other collections revenues, and federal reimbursement. The Department will continue to monitor the expenditures and adjust its savings target accordingly to match projected expenditures. One risk factor is the federal Medicaid matching rate for FFY 13, which will be officially released by the federal government in November. The rate is based on each state's per capita income compared to the national average. Projections by one national analytical group indicates Wisconsin's match rate will decrease by .79% from FFY 12 to FFY 13, which would decrease federal funding by approximately $30 million in the 2011-13 biennium.

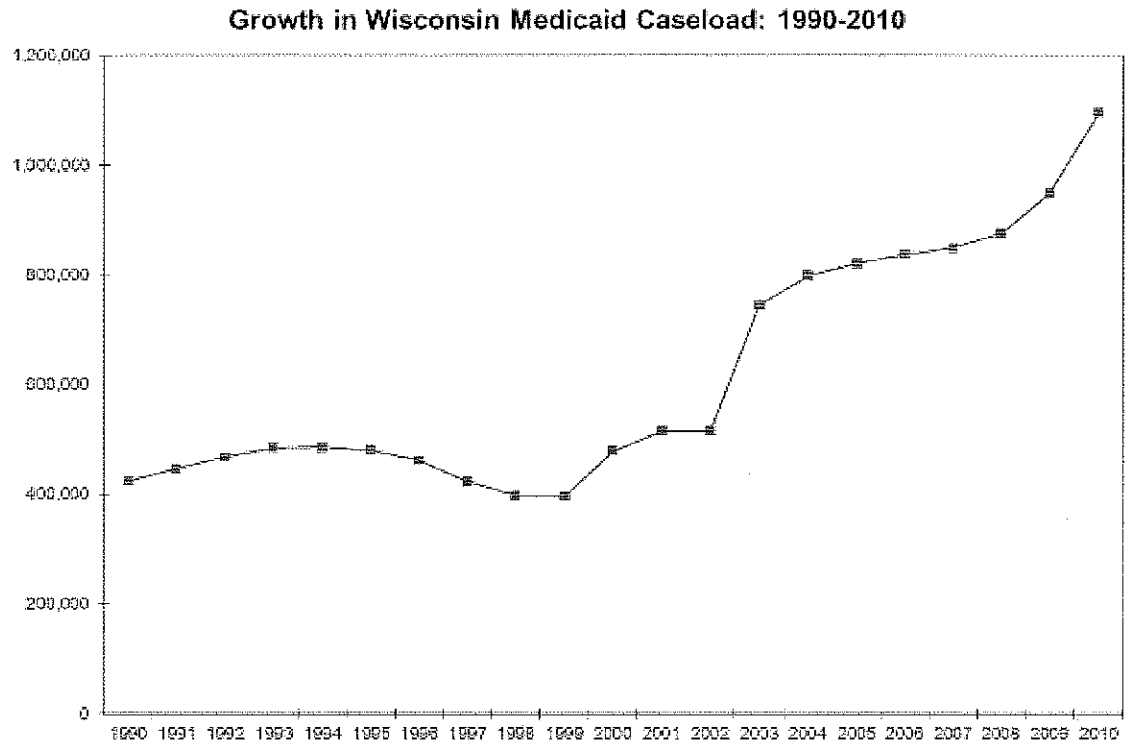
Commonsense Changes to Medicaid: Fair and Focused
Attached for your information is a report summarizing Medicaid reform items the Department has or is working to implement to achieve the necessary savings target for the current biennium.

To generate these ideas, the Department has had numerous discussions with consumers, providers, advocates, members of the public, including several town hall meetings conducted across the state last spring. We are posting these ideas on the Department's website and plan to hold a public hearing to seek further input. The Department is also complying with federal public notice requirements for items that involve Medicaid state plan amendments and waivers.

The mission and cost of Medicaid in Wisconsin have expanded dramatically over the years. One out of every five citizens is now served in one of our various programs (traditional Medicaid, BadgerCare Plus, SeniorCare, and Family Care). Based on 2008 claims data, Medicaid pays for 45 percent of all births in the state. Medicaid recipients occupy roughly 60 percent of nursing home beds.

State funding for Medicaid had to be significantly increased above last biennium's budget, primarily for two reasons – one time federal matching funds decreased by $1.33 billion and the previous budget estimates were based on a projected decline in enrollment. But even after an infusion of $1.2 billion of additional state funding for the current budget cycle, we need to find savings to keep the program in balance with the state budget.

Current enrollment in Medicaid is now 1.1 million individuals. Over the past 20 years, the total population of Wisconsin has increased 16 percent, but Medicaid enrollment has jumped 156 percent.



One out of three children in Wisconsin is now on Medicaid. Medicaid is no longer exclusively for individuals living below the poverty level. More than 120,000 children live in families with income above the federal poverty level; nearly half of these children live in families with income above 150 percent of the federal poverty level.

The picture of how individuals are covered by insurance has changed dramatically over the years. According to data from the Wisconsin Family Health Survey, in 1997, the year in which the state Children's Health Insurance Program (S-CHIP) was created, 76 percent of children living in families with income between 100 and 200 percent of the federal poverty level (FPL) were covered by private insurance. In that year, just 14.5 percent of children in that income category were covered by public programs. By 2009, children with private coverage had declined to 56 percent and public coverage (principally through our Medicaid programs) had increased to 43 percent.

Although the switch between public and private coverage has been dramatic, it is still important to understand that most children living in families with income between 100 and 200 percent FPL are covered by private insurance and the parents of these children are therefore bearing the cost of coverage (as well as contributing to the cost of those on the Medicaid programs through taxes). Moreover, Medicaid provides a richer benefit package for children than what is typically offered in the private sector.

In 1997, only 6.5 percent of adults (ages 18-64) with income between 100 and 200 percent FPL were covered by a public program and 70 percent were covered by private health insurance. By 2009, 30 percent of such individuals had public coverage and those with private coverage dropped to 49 percent.

There are approximately 53,000 non-disabled, non-elderly adults on Medicaid with income above 133 percent of FPL. The federal government has advised that these individuals can be dropped from coverage, which would save the state over $60 million GPR per year. We are determined to avoid this option, but believe it is a matter of fairness that families enrolled in Medicaid, who have income comparable to their neighbors, should be expected to contribute a reasonable amount to the cost of their coverage.

Last year, more than 1.4 million individuals were enrolled in Medicaid for at least part of the year. However, spending is concentrated among a small group of individuals. Over half of enrollees incurred costs of $1,000 or less in 2010 and accounted for less than 5 percent of total costs. But 58 percent of all Medicaid spending was made on behalf of just 5 percent of the population. There are about 40,000 individuals who are elderly or have a disability (or both) enrolled in the Family Care program, which provides supports and services to those in need of long term care. Their combined Medicaid costs (long term care and acute medical care) exceed $1.5 billion. Many of the individuals in Family Care are also enrolled in Medicare but those costs are not included.

The savings measured described in the attached report address these factors that are driving costs in the Medicaid program. Savings are generated across each of the four different categories of reform – eligibility, benefits, service delivery, and payment.

Items for Committee Review under s. 49.45(2m)(d)

A certain number of the reform items included in the attached report require Committee review under s. 49.45(2m)(d). As indicated above, we will formally submit these items to the Committee at a later date once the Department seeks additional public input.

Program Changes Implemented to Date
Finally, Appendix I contains a summary of Medicaid program changes the Department has implemented in this quarter related to the routine administration of the program or federal mandates.

Thank you for your consideration of this information. If you have any questions, please feel free to contact me.

Sincerely,

Dennis G. Smith
Secretary

cc: Members of the Joint Committee on Finance
Legislative Fiscal Bureau

Appendix I
FY 12 Medicaid Program Changes Implemented as of October 1, 2011

1. Family Care Enrollment Cap *July 2011*

2. Non-Emergency Medical Transportation Management System *July 2011*

3. Brand Name Prescription Drug Reimbursement Reform *October 2011*

4. End Stage Renal Disease Part B Modification *September 2011*

5. Hospital Medicare Part A Modification *September 2011*

6. Enhanced Third Party Liability Identification *September 2011*

7. Increase exemption amount for irrevocable burial trusts from $3,000 to $4,500. *September 2011*

8. Update nursing home rates and methodologies to reflect Act 32 changes *July 2011*

9. Update hospital rates and methodologies to reflect Act 32 changes *July 2011*

10. Tobacco cessation counseling services for pregnant women. *September 2011*

11. Elimination of requirement for a physician's prescription for outpatient psychotherapy services and outpatient alcohol and other drug abuse (AODA) treatment services. *September 2011*

2011-2013 MEDICAID EFFICIENCIES

List of Proposals

Payment Reform

1. Aligning Personal Care Payment Policies
2. Brand-Name Prescription Drug Reimbursement Reform
3. Eliminate Hospital Intensity Increase
4. End Stage Renal Disease Part B Modification
5. Enhanced Third Party Liability Identification
6. Federal Claiming Enhancements
7. Hospital Medicare Part A Modification
8. Implementation of the Accelerated School Based Services Project
9. Implementation of the Enhanced Ambulatory Patient Grouping System for Outpatient Hospital Reimbursement
10. Increased Auditing and Auditing Enhancements
11. Managed Care/Fee-for-Service Payment Review
12. Pay for Performance for HMOs
13. Pay for Performance for Hospitals
14. Physician Rate Change for Certain Services Provided in a Hospital
15. Reimbursement Modification for Consultation Services
16. Recovery Audit Contractors
17. Reimbursement Equity
18. Specialty Pharmaceutical Management
19. SSDI/SSI Workload Repayment
20. Wisconsin Medicaid Cost Reporting (WIMCR) Reform

Service Delivery Reform

21. Birth to 3 Program Benchmark Plan
22. Children in Foster Care Medical Home Initiative
23. Conversion of 1915(i) Home and Community Based Services to 1937 Benchmark Alternative Benefits Plan
24. Family Care Enrollment Cap
25. Healthy Birth Outcome Medical Home for Pregnant Women
26. Long-Term Care Pilot Program – Virtual PACE
27. Medical Home for Individuals with HIV/AIDS
28. Medical Home for Individuals with a Mental Health Diagnosis
29. Medical Home for Individuals Leaving the Criminal Justice System
30. Medical Home for Individuals with Two or More Chronic Conditions
31. Non-Emergency Medical Transportation Management System
32. Non-Emergency Medical Transportation Management System-Southeast Wisconsin HMO Members

Benefit Reform

33. Alternative Benchmark Plan
34. Maximize Drug Rebate Collections
35. Wisconsin Pharmacy Quality Collaborative (WPQC) Participation

Eligibility Reform

36. Asset Test Enhancement
37. Divestment Policy Reforms
38. Eligibility Determination Integrity
39. Maintenance of Effort (MOE) Waiver Request of Eligibility Restrictions Established under PPACA

2011-2013 MEDICAID EFFICIENCIES

Aligning Personal Care Payment Policies

Category:	Payment Reform
Focus Area:	Long-Term Care Medicaid
Projected Savings:	$2.7 million GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	State Plan Amendment

Description:

The Department will realign the delivery of personal care delivered as fee-for-service Medicaid services with Family Care policies ensure the cost-effective and efficient delivery of services.

- Currently, personal care costs have increased significantly in Medicaid fee-for-service.
- Data on personal care from fiscal year 2011:
  - $163.2 million all funds (AF) for personal care services to 11,633 members
    - $152.55 million AF for direct services for 11,633 members
    - $9.04 million AF for travel time for 5,121 members
    - $1.68 million for Registered Nurse supervision of a personal care worker for 8,931 members
- Personal care agencies are currently responsible for administering the authorization tool used to determine the amount of personal care an individual receives. In addition, personal care providers, unlike other Medicaid providers, are reimbursed at their hourly rate for travel time.
- Currently, Medicaid reimburses providers for travel time at the direct care rate ($16.8/hour) with no limit on distance for travel or an upper limit on the amount of time that can be charged for travel.
- There are currently two reimbursement systems for personal care services; one for people receiving services in Medicaid fee-for-service, and the second within Family Care.
- The current system creates an incentive for providers to provide services to those receiving fee-for-service because rates are typically higher than those in Family Care.
- The Department's plan to align reimbursements consists of the following:
  - Bring personal care delivered as a fee-for-service Medicaid service in-line with Family Care.
  - Revise personal care travel reimbursement from 100% to 50% of the hourly rate.
  - Add codes to allow the Department to conduct independent assessments of personal care service needs to ensure that members receive appropriate care. These codes will also allow the Department to confirm complex cases.

Effect of this change:

- The Department's proposed changes will create a more uniform reimbursement system for personal care reimbursement.
- Independent assessment of members' personal care needs will bring increased integrity to the Medicaid program. Because providers are responsible for determining the amount of service members receive from the provider's agency, there is potential for abuse. The Department's proposal gives the state new tools to ensure that members, especially those with complex medical and long-term care needs, are receiving appropriate care for their individual needs.
- The Department's proposal related to travel costs will bring needed accountability to these expenditures that are not direct care related.

2011-2013 MEDICAID EFFICIENCIES

Brand-Name Prescription Drug Reimbursement Reform

Category:	Payment Reform
Focus Area:	Pharmacies
Projected Savings:	$2.3 million GPR
Proposed Implementation Date:	October 1, 2011
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

Wisconsin's Medicaid program, beginning October 1, 2011 will convert from the use of Average Wholesale Price (AWP) to the use of Wholesale Acquisition Cost (WAC) as the pricing benchmark for reimbursing pharmacies for brand-name drugs. The Department does not change the current $3.44 dispensing fee paid for each brand-name drug.

- Currently, Wisconsin's Medicaid programs, and 45 other state Medicaid programs, reimburse pharmacies for name-brand medications at a discount of the Average Wholesale Price (AWP) of the pharmaceutical. In Wisconsin, the reimbursement rate has been set at AWP-14%.
- The compendiums of AWP have been historically done by two entities, First Data Bank (FDB) and McKesson Corporation.
- In 2005, a class action lawsuit challenged the validity of the AWP methodology, claiming that the two entities conspired to arbitrarily determine and increase the AWP. Interested parties reached a settlement in 2009.
- **First Data Bank will end publication of AWP's as of the end of September 2011, requiring the state to use a different methodology to calculate reimbursement rates for brand-name prescription drugs.**
- **The Department will convert to Wholesale Acquisition Cost (WAC) methodology for future reimbursement for brand-name drugs.**
- The proposed methodology will move the state from AWP-14% to WAC +2%.

Effect of this change:

- AWP-14% to WAC+2% will provide some savings to the state's Medicaid program. It is estimated that payments to providers will be $2.3-2.6 million GPR lower based on this methodology change.
- The Department believes this change will be more in line with the actual cost of obtaining brand name drugs and will enhance program oversight.
- Although the state budget required the Medicaid program to identify savings of over $181 million GPR, the savings from this proposal will be used to reinvest in quality improvement and outcome based pilots with state pharmacies.
- The Department is working with stakeholders to expand the use of medication therapy management to coordinate patients' medications. This is part of the Department's overall efforts to expand the use of care coordination to improve overall health outcomes.
- This effort is also part of the Department's overall goal of increasing the supply of health care providers by expanding the use of current providers and providing incentives for them to be "Care Extenders."

2011-2013 MEDICAID EFFICIENCIES

Eliminate Hospital Intensity Increase

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$7.2 million GPR
Proposed Implementation Date:	July 1, 2011
Implementation Requirements:	2011-13 State Budget and State Plan Amendment (SPA)

Description:

The Department, per the 2011-13 state budget, payments made to hospitals by eliminating the intensity increase initially included in the Department's 11-13 budget submission.

- Payments to hospitals for inpatient services are based on a number of factors including the health status of a beneficiary, volume (the number of services) and intensity (an x-ray versus MRI).
- The Department's 11-13 biennial budget request included a 2% increase over base reflect an increase in hospital intensity.
- Due to state fiscal pressures, the 2011-13 budget does not include the 2% intensity increase, leaving hospital base funding level from FY2011.

Effect of this change:

- This budget change maintains base level funding for hospitals by not accepting the proposed 2% intensity rate increase.

2011-2013 MEDICAID EFFICIENCIES

End Stage Renal Disease Part B Modification

Category:	Payment Reform
Focus Area:	BadgerCare Plus, Medicaid, Wisconsin Chronic Disease Program
Projected Savings:	$1.3-1.5 million GPR
Proposed Implementation Date:	September 10, 2011
Implementation Mechanism:	2011-13 State Budget via a State Plan Amendment (SPA)

Description:

The Department, effective September 10, 2011, modified payments made to entities that provide end stage renal disease (ESRD) services.

- Previous to this payment reform measure, Medicaid paid ESRD services based on Medicare reimbursement methodology.
- Medicaid reimburses for several other services at approximately 80% of the Medicare. To align ESRD more closely with other services, the Department has undertaken steps to develop a new reimbursement methodology using a per diem rate not to exceed 80% of Medicare payments.

Effect of this change:

- This change in payment policy will better align Medicaid ESRD reimbursement with other Medicaid benefit areas. It will also allow for more flexibility in pricing, which was not possible under the former reimbursement policy.

2011-2013 MEDICAID EFFICIENCIES

Enhanced Third Party Liability Identification

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$3.6 million GPR
Proposed Implementation Date:	Fall 2011
Implementation Mechanism:	Current contracts

Description:

Currently, under state law Medicaid is the payer of last resort and requires private insurance to pay medical care costs when coverage is available. When the Department is aware that a Medicaid member has other insurance (third party insurance), the Department will ensure that the third party obligation is met before Medicaid pays. The Department will employ enhanced resources to better identify third party liability.

- Currently, Medicaid identifies other insurance through a data exchange between private insurance companies and the Department. However, these current submissions do not include information regarding self funded plans or limited benefit coverage such as a prescription only drug benefit.
- By employing additional resources to identify third party liability currently unaccounted for, the Department will mitigate reimbursing for costs that are covered by other third party payers.

Effect of this change:

- The Department will be able to realize enhanced identification of third party liability for Medicaid members by using a contracted vendor to identify situations where members have other coverage.
- As a result, expenditures currently being paid by the Medicaid program will be paid by other third parties, thus decreasing Medicaid expenditures without reducing benefits to members.

2011-2013 MEDICAID EFFICIENCIES

Federal Claiming Enhancements

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$8.3 million GPR
Proposed Implementation Date:	On or before March 1, 2012
Implementation Requirements:	Claims Systems Changes

Description:

The Department will review the current process used to obtain funds from the federal government and implement system enhancements and policy changes to allow the Department to more accurately claim federal funds.

- Medicaid benefits are funded with a combination of state and federal funding. The Department is responsible for claiming the associated federal funds for benefits provided.
- As the scope of programs covered under Medicaid has grown to represent over $7 billion of health care expenditures annually, Medicaid claims processing activities have become increasingly complex. This heightened complexity requires an evolving quality control response.
- Federal claiming rates can vary based on the type of benefits provided and individuals receiving the services. This complexity leads to numerous different federal matching rates.

Effect of this change:

- By implementing system enhancements and policy changes, the Department will have more specific information when claiming federal funds. This will ensure the Department receives full federal support for services currently being provided to Medicaid members that the Department is entitled to.

2011-2013 MEDICAID EFFICIENCIES

Hospital Medicare Part A Modification

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$6.0 million GPR
Proposed Implementation Date:	September 9, 2011
Implementation Requirements:	2011-13 State Budget via State Plan Amendment (SPA)

Description:

The Department, effective September 9, 2011, modified payments made to hospitals on behalf of certain individuals who are eligible for both Medicare and Medicaid (dual eligible) and who meet certain financial criteria.

- Previous to this reform measure, certain individuals who are eligible for both Medicare and Medicaid (dual eligibles) had coinsurance and deductibles under his/her Medicare Part A obligation fully paid by Medicaid.

- Under this payment methodology, Medicaid paid the full amount of the individual's Medicare Part A coinsurance and deductible obligation even if the combination of the Medicaid coinsurance, deductible, and Medicare reimbursement exceeded the Medicaid allowable charge for the same service as illustrated in the example below:
    - Medicare's reimbursement rate is $100 for a service with a $20 coinsurance obligation while the Medicaid allowable cost for that same service is $90. Currently, Medicaid pays the full $20 coinsurance. This results in a total reimbursement of $100 despite the Medicaid allowable cost being only $90 for that service.

- The Department has undertaken steps to remove discrepancies between Medicare and Medicaid payments to identify budget savings and provide equity between programs for the payment of similar services.

Effect of this change:

- Under this proposal, providers will receive the same reimbursement for services provided to dual eligible as they would receive for services to non-dual Medicaid eligibles.

    - Using the same illustration as above, Medicare's reimbursement rate is $100 for a service with a $20 coinsurance obligation while the Medicaid allowable cost for that service is $90. Under the payment reform, Medicaid would pay only $10 for coinsurance. In this scenario, the total amount paid to the provider would be $80 (Medicare reimbursement) + $10 (Medicaid coinsurance) = $90. This is the same dollar amount that Medicaid considers an allowable cost for that service.

- This reform will better align Medicaid payments across various eligibility categories.

2011-2013 MEDICAID EFFICIENCIES

Implementation of the Accelerated School Based Services Project

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$6.3 million GPR
Proposed Implementation Date:	On or Before July 1, 2012
Implementation Requirements:	Systems Changes

Description:

The Department will update the Medicaid School Based Services (SBS) interim claims process resulting in additional one time federal funding for the 2011-13 biennium.

- Medicaid claims federal funding for certain school based medical services provided to Medicaid eligible students.
- Currently, all school district are reimbursed at the same interim rate for services provided. After the end of the school year a cost settlement is performed to claim the federal funds associated with the cost of providing these services.
- School districts provide the local funding for these services and the Department claims the associated federal funds for these services. School districts receive 60% of the associated federal funds and the state retains 40% of the federal funds.
- Since the interim claiming rate is the same for all school districts, reimbursement to school districts with higher costs are not accurately reimbursed at the time the service is performed.
- To address this, the state will update interim rates based on historical costs.

Effect of this change:

- This change will increase federal claiming at the time the services are provided allowing school districts to receive funding in a timelier manner and create a one time increase in federal claiming.

2011-2013 MEDICAID EFFICIENCIES

Implementation of the Enhanced Ambulatory Patient Grouping System for Outpatient Hospital Reimbursement

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$1.6 million GPR
Proposed Implementation Date:	Late 2012
Implementation Requirements:	State Plan Amendment (SPA)

Description:

The Department will implement the Enhanced Ambulatory Patient Grouping System (EAPGs) for Outpatient Hospital Claims reimbursement.

- Currently, outpatient hospital services are reimbursed one rate per visit per day regardless of what services are provided during that visit. This per visit rate is not differentiated based on the cost of care provided.
- For example, if a Medicaid recipient receives treatment for a sinus infection in an outpatient hospital-based clinic, the hospital would receive the same reimbursement as treatment of a broken arm even though the costs for such services vary.
- Similar to the way hospitals are reimbursed for inpatient hospital services using the Diagnosis Related Grouper (DRGs) and physicians are paid based on a maximum allowable fee schedule, the Department will be begin using a grouping system for outpatient hospitals services that ties the cost of services provided to the reimbursement the provider receives.
- The Department will transition to EAPG reimbursement. The Enhanced Ambulatory Patient Grouper system is a patient classification system designed to explain the quantity and type of resources used in an outpatient hospital setting.

Effect of this change:

- Under this proposal, hospitals will be reimbursed for outpatient hospital services based on the quantity and type of services they provide.
- This policy will ensure that low cost services and high cost services are reimbursed appropriately.

2011-2013 MEDICAID EFFICIENCIES

Increased Auditing and Auditing Enhancements

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$14.9 million GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	2011-13 State Budget

Description:

The Department will improve Medicaid program integrity by increasing the number of contract auditors by 10 full time employees (FTE). In addition, the Department will implement extrapolation policies when fraud is identified and require provider/patient face-to-face contact for home care and durable medical equipment (DME) fraud.

- Currently, the Department conducts audits aimed at preventing billing fraud. In addition, these audits ensure that claims paid are consistent with Medicaid billing and payment policies.
- Given the size of the Medicaid program, prevention, detection and investigation of fraud and overpayments is a top priority for the Department.
- The Department's Bureau of Program Integrity currently conducts program audits on Medicaid providers.
- The Department is revamping its overall fraud efforts to improve audit capabilities. An important part of these efforts is the additional contract auditors provided by the 2011-13 State Budget and mandated by the Patient Protection and Affordable Care Act (PPACA).
- Because of the increase in auditing capability, the new contract positions will increase the state's ability to prevent improper payments while increasing the Department's ability to identify and recoup fraudulent payments to providers. The return on investment for these positions should exceed the cost of the new contract positions.
- The state will also have the technical resources to use extrapolation in establishing Medicaid overpayment amounts. This methodology, used in other states, will help the Department better determine overpayments in cases where the overall payments are difficult to determine initially.

Effect of this change:

- The Department is making auditing, fraud detection and investigation efforts a top priority.
- These increased efforts will protect taxpayer dollars and bring additional program integrity to the Medicaid program.
- The efforts of the new contract auditors will focus primarily on Medicaid providers.
- The Department, through the addition of $2 million GPR and 19 state FTE positions in the 2011-13 state budget, is expanding and improving its overall fraud detection efforts by increasing current auditing efforts aimed at member fraud and trafficking in Medicaid and other programs like FoodShare.

2011-2013 MEDICAID EFFICIENCIES

Managed Care/Fee-for-Service Payment Review

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$2.0 million GPR
Proposed Implementation Date:	Fall 2011
Implementation Mechanism:	Systems Changes and Audit

Description:

The Department will review fee-for-services payments to determine if payments were inappropriately made for Medicaid members who are enrolled in managed care entities.

- Currently, Medicaid provides health benefits through the use of managed care or through direct payments to providers through fee-for-service.
- The Department, through increased auditing efforts, is working to ensure that inappropriate billing is not occurring within Medicaid. The review of payments to managed care providers and the fee-for-service will identify inappropriate payments and will allow the state to seek recovery.
- An initial review has identified potential overpayments resulting from the following:
  - Duplicate payments
  - Payments made for dates of service occurring after the death of the Medicaid member
  - Payments for services for which the member was not eligible
  - Payments for non-covered services
- Additionally, the Department has now fully deployed the National Correct Coding Initiative system edits to reduce the possibility of future inappropriate payments.

Effect of this change:

- The Department is making auditing, fraud detections and investigation efforts a top priority.
- These increased efforts will protect taxpayer dollars and bring additional program integrity to the Medicaid program.
- This proposal will identify duplicative payments and allow the Department to seek recovery of these overpayments.
- The Department, through the addition of $2 million GPR and 19 state FTE positions in the 2011-13 state budget, is expanding and improving its overall fraud detection efforts by increase current auditing efforts aimed at member fraud and trafficking in Medicaid and other programs like FoodShare.

2011-2013 MEDICAID EFFICIENCIES

Pay for Performance for HMOs

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$700,000 GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	HMO contracts

Description:

The Department will work to improve health care outcomes by enhancing the HMO pay for performance (P4P) program in Medicaid.

- Since 2009, the Department has implemented a P4P program as part of its efforts to continue to improve quality outcomes and move Medicaid from a system based on volume to one based on value.
- Currently, the Department withholds 1% of the capitation rate of HMOs serving BadgerCarePlus and SSI members; HMOs can earn this back by attaining specific goals related to health care quality.
- For Calendar Year 2012, the Department will withhold 1.5%, amounting to approximately $10 million for BadgerCarePlus and SSI.
- HMOs that attain all the specific P4P goals can potentially earn a bonus, subject to certain limitations, in addition to the withheld amounts. The bonus pool will be entirely funded by forfeitures by the HMOs that did not attain all their P4P goals.

Effect of this change:

- HMO P4P is one part of the Department's overall goal of reforming Medicaid benefit delivery and payment into systems based on quality outcomes and value, not volume.
- Through the P4P program, HMOs and the Department track key health care indicators aimed at improving the quality of health care delivery.
- Based on preliminary comparisons of 2009 and 2010 performance, the P4P program has already demonstrated improvements in HMO performance on a variety of health care quality measures.

2011-2013 MEDICAID EFFICIENCIES

Pay for Performance for Hospitals

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$5.0 million GPR
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

The Department will work to improve health care outcomes by expanding and improving the hospital pay for performance program to improve health outcomes in Medicaid.

- Currently, the Department pays certain hospitals for performance and reporting related to selected performance measures.
- In an effort to continue to improve quality outcomes and move Medicaid from a system based on volume to one based on value, the Department is working with stakeholders and Wisconsin hospitals in developing a series of pay for performance measures (P4P) and tying part of hospital reimbursement to these new measures.
- Ongoing collection of patient data by the Department will allow tracking of improvements achieved. As performance improves for a specific measure, the Department will provide additional reimbursement for the hospital.
- Funding for the P4P program is from a 1.5% holdback from the state's Medicaid budget for hospitals. The Department's proposal would allow for the full 1.5% to be claimed by hospitals as P4P goals are met.

Effect of this change:

- Hospital P4P is one part of the Department's overall goal of reforming Medicaid benefit delivery and provider payment into systems based on quality outcomes and value, not volume.
- Through the P4P program, hospitals and the Department will track key health care indicators aimed at improving both the delivery of care and quality of overall health outcomes.
- The P4P program will also encourage the implementation of best practices, especially for adults and children with complex health conditions.

2011-2013 MEDICAID EFFICIENCIES

Physician Rate Change for Certain Services Provided In a Hospital

Category:	Payment Reform
Focus Area:	Medicaid Physicians
Projected Savings:	$1.5 million GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

The Department will adjust the rate paid to physicians for services typically provided in an office setting when those services are instead provided in a hospital setting.

- The adjusted rate for these services when provided in a hospital setting will both account for the physicians' lower overhead costs in a hospital setting
- The Department's proposed rate change creates an incentive to provide these services in an office setting when clinically appropriate.
- For purposes of this provision, hospital settings include inpatient and outpatient hospitals, ERs, and ambulatory surgery centers.
- The adjusted physician reimbursement for these services when provided in a hospital setting will be set at 80% of the physician reimbursement rate when provided in an office setting.

Effect of this change:

- This provision will adjust reimbursement rates to better reflect the cost of providing care in different settings.
- This modification is part of the Department's overall efforts to better align Medicaid reimbursements.

2011-2013 MEDICAID EFFICIENCIES

Reimbursement Modification for Consultation Services

Category:	Payment Reform
Focus Area:	Medicaid Physicians
Projected Savings:	$1.6 million GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

The Department will modify its methodology for Medicaid reimbursement of consultation services.

- Currently, Medicaid provides reimbursement to providers for consultation services requested by another provider to obtain a medical opinion.
- Effective January 1, 2010, changes to Medicare at the federal level adjusted Medicare part B fee-for-service reimbursement for consultation services to better match reimbursement for other primary care services.
- The Department will change Medicaid reimbursement for consultation services with new reimbursement rates set at 80% of current Medicaid rates.

Effect of this change:

- The Department recognizes the value of consultation services as a means of improving overall health outcomes for patients. This provision will maintain coverage of these services while adjusting reimbursement rates to better align with other primary care services.
- This modification is part of the Department's overall efforts to better align Medicaid reimbursements.

2011-2013 MEDICAID EFFICIENCIES

Recovery Audit Contractors

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$3.0 million GPR
Proposed Implementation Date:	Early 2012
Implementation Mechanism:	System Changes and Contractor Audits

Description:

The Department will contract with Recovery Audit Contractors (RAC) to reduce improper Medicaid payments and implement actions to prevent future improper payments.

- The federal Patient Protection and Affordable Care Act (PPACA) requires that state Medicaid programs develop a program to contract with a private entity or entities to serve as Recovery Audit Contractors (RACs).
- On September 14, 2011, the Centers for Medicare & Medicaid Services (CMS) released a final rule detailing implementation of the Medicaid RAC program The Medicaid RAC program is based on a similar Medicare program that is currently in operation nationwide.
- States will contract with the Medicaid RACs, which will search for fraud, waste and abuse in the program by reviewing past claims that already have been paid. Auditors will be compensated based on a percentage of funds they recover that were paid inappropriately to doctors, hospitals and others.
- The final rule also directs states to pay reviewers for uncovering underpayments that must be reimbursed to those filing the claims.
- Although the Medicaid RAC program is similar to the Medicare version that is currently operating nationwide, the final rule includes several revisions requested by the health care industry. For example, each Medicaid RAC must hire a physician as medical director. CMS also allows states to set a limit on the number of records that can be requested and limits the "look back" period for audits to 3 years.

Effect of this change:

- The Department is making auditing, fraud detection and investigation effort a top priority.
- Initiatives like the RAC program will protect taxpayer dollars and bring additional program integrity to the Medicaid program.
- The Department, through the addition of $2 million GPR and 19 state FTE positions in the 2011-13 state budget, is expanding and improving its overall fraud detection efforts by increase current auditing efforts aimed at member fraud and trafficking in Medicaid and other programs like FoodShare.

2011-2013 MEDICAID EFFICIENCIES

Reimbursement Equity

Category:	Payment Reform
Focus Area:	Reimbursement
Projected Savings:	$5 million GPR
Proposed Implementation Date:	Starting Oct 1, 2011
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

Currently, the Department has varying reimbursement rates for the same services when provided in different settings. These differences in reimbursements lead to incentives to provide care in the setting that yields the highest reimbursement. In addition, some providers are guaranteed to be reimbursed the full cost of Medicaid services regardless of whether the care is delivered in a cost effective manner through cost based reimbursement.

- Due to the historical practice of developing reimbursement rates based on where a service is provided (e.g. outpatient hospital, physician clinic, community health center), rates for performing the same services may vary significantly depending on service location.
- This inequity has developed over time as technology allows services to be delivered in multiple settings. For example a therapist in an outpatient hospital setting may perform the exact same service as provided in a clinic while the reimbursement is higher for the therapist in the hospital.
- For certain providers, Medicaid guarantees that the provider will be reimbursed the full cost of providing services. This practice does not facilitate cost effective care and leads to similar health care services being reimbursed at significantly different rates depending on their provider designation.
- Where guaranteed cost based reimbursement is necessary, the Department will review reimbursement relative to their peers to ensure that providers are incentivized to provide cost effective care.

Effect of this change:

- This change will ensure that Medicaid reimbursement is equitable regardless of provider setting and ensures that the Medicaid program maintains a robust provider community with service delivery options. This will incentivize cost effective care.

2011-2013 MEDICAID EFFICIENCIES

Specialty Pharmaceutical Management

Category:	Payment Reform
Focus Area:	All Medicaid Populations
Projected Savings:	$2 million GPR during FY13
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	Medicaid Systems Changes

Description:

- Specialty pharmaceuticals are considered to be high-cost injectable, infused, oral or inhaled biotech medications that require patient monitoring and professional support.
- These pharmaceutical are expensive and historically fall outside of traditional cost containment initiatives. Specialty pharmacy represents 25% of total Medicaid pharmacy spend and industry forecasts show that specialty pharmacy could grow to 50% of pharmacy spend by 2014.
- Wisconsin Medicaid will pursue increased controls and monitoring of these expensive biologic drugs by reviewing where these drugs are administered, implementing utilization controls, and achieving discounts through preferred purchasing methodologies.

Effect of this change:

- Wisconsin Medicaid will bend the cost curve for this growing health care sector to achieve long-term savings for the Medicaid program.

2011-2013 MEDICAID EFFICIENCIES

SSDI/SSI Workload Repayment

Category:	Payment Reform
Focus Area:	Medicaid
Projected Savings:	$45.0 million GPR (one-time)
Proposed Implementation Date:	2012
Implementation Mechanism:	Waiver

Description:

The Department will continue to collaborate with other states in developing a demonstration project with the US Department of Health and Human Services (DHHS) to recoup funding lost by systemic errors in the Social Security Administration (SSA) method for determining eligibility for federal disability benefits.

- Currently, two federally-administered programs provide income for people who are not able to work because of age or disability. Supplemental Security Income (SSI) provides support for people who are aged, blind or disabled while Social Security Disability Insurance (SSDI) provides income for qualified individuals with disabilities.
- Individuals enrolled in SSI are eligible for Medicaid while people receiving SSDI are enrolled in Medicare.
- For 30 years, SSA erroneously enrolled hundreds of thousands of people into SSI who should have been enrolled in SSDI.
- This error caused states to make Medicaid payment for individuals who should have been on SSDI and enrolled in Medicare.
- It is estimated that had Medicare paid providers for the care that Medicaid in fact paid, Medicare costs would have been $10 billion higher.
- The system eligibility error has been acknowledged by the SSA, and over the past ten years the agency has implemented the Special Disability Workload (SDW) project to correct this error and restore the cash benefits that were wrongfully withheld from individuals.
- This error forced states to pay for health and income benefits that should have been paid by the federal government.
- This Department's proposal is receive reimbursement for state expenditures that were erroneously made due to this mistake.

Effect of this change:

- Federal errors in eligibly have caused Medicaid to make payments for services that should have been paid by the Federal government.
- It is estimated that the state could receive over $45 million in repayments based on the current caseload reviews.
- This money would be a one-time increase for the Department and the Medicaid program.

2011-2013 MEDICAID EFFICIENCIES

Wisconsin Medicaid Cost Reporting (WIMCR) Reform

Category:	Payment Reform
Focus Area:	Medicaid Administration and Counties
Projected Savings:	$19.2 million GPR
Proposed Implementation Date:	January 2012
Implementation Mechanism:	Systems Change

Description:

The Department has been granted the authority to transition the current Wisconsin Cost Reporting (WIMCR) claiming process from an all-funds payment to a certified public expenditure (CPE) claim effective with calendar 2012 dates of service.

- WIMCR is the process by which the state claims Medicaid federal match dollars for county costs for providing certain community-based Medicaid services. This payment is in addition to the Medicaid fee-for-service reimbursement rate. The WIMCR process is as follows:
  - Counties bill the state's Medicaid vendor through the usual fee-for-service process and are reimbursed at the basic fee-for-service Medicaid rate.
  - In May of each year, counties submit reports to the Department electronically showing their full cost for providing those services. These cost reports are reviewed to ensure accuracy and quality.
  - In autumn of each year, the Department makes an all funds Medicaid payment adjustment to the county equal to the difference between the basic Medicaid fee-for-service reimbursement rate and the full cost of the service as reported by the county.
  - The Department reduces the Community Aids grant allocations by the amount of the Medicaid payment adjustment and an additional $19.25 million reduction. Through this process, counties receive a majority, but not all of, the federal gain from the WIMCR process.
- The 2011-13 state budget grants the Department the ability to transfer from the current WIMCR process to a certified public expenditure process. Under a CPE process:
  - Counties continue to submit annual cost reports, per the current process.
  - The Department makes a CPE federal claim, based on the cost reports.
  - The Department pays counties a portion of the federal claim, equivalent to their current share, and deposits the remainder in the Medicaid Trust Fund.
  - The All Funds payment adjustment/Community Aids contract cuts are discontinued.

Effect of this change:

- The current WIMCR cost reporting, payments, and Base Community Aids adjustments create a significant administrative workload and complexity for county and Department staff. Switching to a CPE would greatly simplify the process for the Department and counties.
- The Legislative Audit Bureau has been critical of contracting processes where contract funding is disproportionally distributed between two fiscal years of two biennial budgets. Reforming the system to CPE will address this issue and increase accounting integrity for the Department.
- Due to these changes, it is estimated that there is a one-time GPR savings of $19.2 million GPR.

2011-2013 MEDICAID EFFICIENCIES

Birth to 3 Program Benchmark Plan

Category:	Service Delivery
Focus Area:	Birth to 3 Program
Projected Savings:	Budget Neutral
Proposed Implementation Date:	2012
Implementation Mechanism:	1937 State Plan Amendment

Description:

The Department will implement a benchmark benefit plan for children who are currently in the Birth to 3 program. The plan will allow the state to leverage federal funding for certain services, maximizing the investment currently made by the state and counties in Birth to 3 services.

- The Birth to 3 Program is Wisconsin's early intervention program for infants and toddlers with developmental delays and disabilities and their families.
- Currently, the Birth to 3 Program uses a combination of federal education funds, state, county and Medicaid funding to provide these services to children.
- The program has identified a number of best practices to improve the quality of care children receive in the program. However, because of the multi-pronged funding system for the program, some of these best-practices are either not used because they are not currently covered by Medicaid or are paid fully with state or county levy dollars.
- The Department will implement a benchmark plan to expand the number of services that are covered by Medicaid. Some of the services that will leverage federal funding under the benchmark are:
  - Early intervention teachers;
  - Home trainers;
  - Parent-to-parent mentors; and
  - Developmental specialists.
- This does not alter the types of services that children eligible for the Birth to 3 Program are receiving.
- The benchmark plan will also incentivize the use of best practices by making these professional services Medicaid eligible rather than having the cost paid fully with county resources.

Effect of this change:

- This benchmark plan is part of the Department's review of current programs to identify program efficiencies and cost savings while improving the health and long-term care outcomes of individuals.
- This change will expand the number of Medicaid eligible services provided under the Birth to 3 program.
- This change does not change the types of services that are available to children in the program.
- Counties providing services should see some levy relief, as the new benchmark plan provides Medicaid reimbursement for services that were previously paid using County funds.

2011-2013 MEDICAID EFFICIENCIES

Children in Foster Care Medical Home Initiative

Category:	Service Delivery Reform
Focus Area:	Children in foster care in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties; Certified Medicaid health care providers
Projected Savings:	$300,000 GPR savings
Proposed Implementation Date:	January 2012
Implementation Mechanism:	1937 State Plan Amendment

Description:

Currently, there are approximately 6,000 children in out-of-home placements who receive Medicaid services in Wisconsin. Many of the foster care children need specialty care and are receiving that care on a fee-for-service basis under Medicaid. As a result, coordinated care may be limited among providers, and may not address the specific needs of children in out-of-home care. The Departments of Health Services and Children and Families are creating a medical home for children in out-of-home care that provides an individualized treatment plan for each child that addresses the child's trauma-related needs, delivers treatment services that are evidence-based and will result in improved behavioral, mental, and physical health for the child and a safer, more stable family setting for the child.

- The primary care provider and care team will assure that each child receives a complete trauma-informed health assessment, and an individual treatment plan, including evidence-based mental health interventions.
- Benefits will be provided under the BadgerCare Plus standard Plan, with added unique features to support children in out-of-home placements. Benefits will include: care coordination, hospitalizations, physicians visits, dental services, laboratory and x-ray services, prescription drugs, behavioral and mental health services, health and well-child screening services, immunizations and urgent and emergency care.
- The child will be eligible to receive care coordination and services through this medical home model for 12 months after a child reunifies with his/her birth family, or moves to an adoptive family or relative guardian to assure continuity of care and treatment, provided they are still eligible for Medicaid after the child's permanency plan is achieved.
- The initiative will begin in Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties and will include approximately 2,500 eligible children.
- Qualified health care providers for the medical home must be an integrated health system with demonstrated capacity in trauma-informed care, evidence-based treatment, and must demonstrate that they have qualified physicians, nurse practitioners and other supportive staff, an adequate network of qualified providers for medical, dental and behavioral health services and the ability to contract with providers outside their network to ensure a full range of services for urgent care and other services to ensure continuity of care for the child.
- The Department of Health Services and the Department of Children and Families will set forth key performance-based measures related to health care and child outcomes that are based upon national standards within the Child Welfare and Medicaid programs.

Effect of this change:

- Some children enter foster care or out-of-home placements at a very young age, a period where the child's development, including mental and psychological development are at a critical point; the separation from birth parents and placement into a new setting in and of itself creates trauma for the child. Older children entering out-of-home care have often had repeated, traumatic experiences and the response to their needs must be rapid and evidence-based to help the child address these trauma-related needs. Children who have been involved in foster care experience higher rates of physical and psychiatric morbidity than the general population because the children have often experienced significant and repeated traumas.

- Creating medical homes for children in out-of-home placements will ensure that their health needs are immediately assessed and addressed with a trauma-informed, flexible, and coordinated approach. These approaches are shown to provide a better path for children to achieve long-term stability.

- Medical homes will allow for access to the child's medical history and the coordinated care will assure timely access to assessment and urgent care. The flexibility of service provision for the child will stabilize the child and support the goals of safety and permanency for the child.

- Many foster children have intensive behavioral and mental health needs. The medical home will coordinate trauma-informed behavioral health treatment, which includes evidence-based practices unique to the needs of each child, oversight of psychotropic medications, flexible service delivery settings, mobile crisis response and stabilization services, and peer-to-peer interventions.

- Certified Medicaid Health Systems will be reimbursed at an all-inclusive rate calculated using current expenditures for this population of children. Many children in foster care receive high cost services and specialty care. Other services are duplicated or less effective interventions. By providing an all-inclusive rate, the Medicaid program anticipates coordinated, best-practice and most appropriate services being provided to children. This will result in long-term savings as a result of positive health and mental health outcomes for children and prevention of reentry into the out-of-home care system.

- The Departments have received input from a wide range of stakeholders and interested parties including, child welfare advocates and providers, human services directors for the counties in the southeastern part of the state included in this initiative, the Milwaukee Child Welfare Partnership Council, the Wisconsin Association of Family and Children's Agencies and the Wisconsin Counties Human Services Association and are continuing discussions with stakeholder groups.

- The Departments are continuing to work with child advocates, providers and the southeast counties to develop quality outcomes and performance measures; provider evaluation criteria; definition of the roles and responsibilities for agencies and providers and mechanisms for coordination, and coordination with the judicial system.

2011-2013 MEDICAID EFFICIENCIES

Conversion of 1915(i) Home and Community Based Services to 1937 Benchmark Alternative Benefits Plan

Category:	Service Delivery Reform
Focus Area:	Individuals with Severe and Persistent Mental Illness
Projected Savings:	Budget Neutral
Proposed Implementation Date:	2012
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

The Department will transition the current 1915(i) Home and Community Based Services for individuals with severe and persistent mental illness to a 1937 Benchmark Alternative Benefits Plan.

- Currently, Wisconsin counties have the ability to claim federal dollars for individuals with severe and persistent mental illness through the state's 1915(i) Home and Community Services State Plan benefit.
- There are 154 people who currently receive services under the 1915(i) benefit. An example of services provided include the following psycho-social rehabilitative services:
  - Community living supportive services which lead to independent living and recovery
  - Peer specialist supports
  - Supported employment
- The Centers for Medicare and Medicaid Services (CMS) under the Patient Protection and Affordable Care Act (PPACA) changed regulations related to 1915(i) Home and Community Based Services to require the program to be statewide with no limit on who can access these services. This change prohibits the state from maintaining the programs' current geographical footprint, and leaves the state and counties with the choice of either statewide implementation or no implementation.
- Due to budget restraints at both the state and county level, full expansion is not feasible. However, by converting the benefit to a 1937 Benchmark Alternative Benefits plan, the state and counties can continue to provide services in the current geographical areas that have willing and engaged providers.

Effect of this change:

- The change to a 1937 Benchmark Alternative Benefits plan will allow the state and selected counties to continue to provide services to individuals with severe and persistent mental illness and will allow for expansion as finances allow.
- This proposal is part of the Department's efforts to improve community based mental health services and treatments while maintaining fiscal stability.
- A key part of this proposal is the use of peer specialist supports. Working in collaboration with stakeholders, the Department continues to look for ways to expand the use of these services. The 1937 Benchmark Alternative Benefits plan includes these supports.

2011-2013 MEDICAID EFFICIENCIES

Family Care Enrollment Cap

Category:	Service Delivery Reform
Focus Area:	Family Care/ IRIS/ PACE/ Family Care Partnership
Projected Savings:	$105.9 million GPR
Proposed Implementation Date:	July 1, 2011
Implementation Mechanism:	2011-13 State Budget and Amendment to Current 1115 Waiver

Description:

The Department, effective July 1, 2011, capped enrollment in Family Care and its related programs (the Family Care Partnership Program, the Program for All-Inclusive Care for the Elderly (PACE), and the Include, Respect, I Self-Direct (IRIS) program) and stopped planned expansion into additional counties.

- Authorized in 1998, Family Care provides long-term care services for adult Medicaid eligible individuals who are frail elders, people with physical disabilities and people with developmental disabilities. As of July 1, 2011, approximately 43,500 individuals were enrolled in Family Care and its related programs on a statewide basis.

- Between 2005 and 2010, the Family Care program expanded from 5 to 53 counties. In this same time period, program expenditures increased from $248.4 million All Funds (AF) in FY 2005-06 to $936.4 million AF in FY 2009-10.

- The rapid growth in the program, concerns about Managed Care Organizations (MCO) and provider solvency, and the accelerated growth rate of the frail elder population, resulted in the Legislative Audit Committee authorizing an audit of the Family Care program in June of 2010. This was the first full review of the program by the nonpartisan Legislative Audit Bureau (LAB) since the program started in 1998.

- In April 2011, the LAB concluded its review of the program, and required the Department of Health Services to report back on a number of issues.

- While the Audit identified a number of program and budget concerns with Family Care, the larger issues of cost-effectiveness and fiscal sustainability were not explicitly addressed in the audit.

- **The Department is completing a comprehensive review of the Family Care program in order to identify necessary changes to the system of long-term care which will allow the state to remove the enrollment caps and allow for planned program expansion to additional counties.**

- **The Legislature provided $25.2 million AF over the biennium for emergency enrollment for people with an urgent need for long-term support services so they can receive assistance.**

Effect of this change:

- As of July 1, 2011, there were approximately 43,500 people enrolled in Family Care, Family Care Partnership, PACE and IRIS. The enrollment cap creates a maximum number of people who can participate in these programs at any given time. New individuals are enrolled through attrition within this maximum enrollment number. The maximum enrollment will be maintained at 43,500 people until the needed program and policies changes can be defined and implemented.

- The enrollment cap allows the Department to evaluate the existing programs in their entirety before more people are enrolled and these programs expand to the entire state. This needed review, sparked by the Audit, will lead to policies and budget decisions that strengthen these programs, ensure that care is being coordinated in an efficient and cost-effective manner, and create new opportunities for people to live in community settings.

- The review of the program will focus on developing new opportunities for individuals to direct their own long-term care. While people may need assistance in their day-today activities, they should have the support and resources to live their own lives in their own communities.

- In a series of Town Hall meetings held before the enactment of the state budget, the Secretary and Deputy Secretary of the Department heard from consumers, providers, advocates and stakeholders on their concerns with these programs, as well as their ideas to improve the delivery of service and lower costs. The Department has compiled input from these meetings, published them online, and is using this input as part of the Department's overall efforts to increase quality, improve health outcomes and control costs.

2011-2013 MEDICAID EFFICIENCIES

Healthy Birth Outcome Medical Home for Pregnant Women

Category:	Service Delivery Reform
Focus Area:	Pregnant Women in Fee-for-service Medicaid
Projected Savings:	$900,000 GPR
Proposed Implementation Date:	2012
Implementation Mechanism:	State Plan Amendment

Description:

The Department will submit a state plan amendment to create a medical home for pregnant women on fee-for-service Medicaid. The medical home will coordinate care for the pregnant mother and her baby to ensure a healthy pregnancy.

- Currently, approximately 10,000 mothers in fee-for-service give birth annually.
- Since these mothers are in fee-for-service, their care is not being coordinated or monitored as well as it could be. The lack of coordination can lead to poor health outcomes for a mother and her baby as well as premature births. The result is an increase in cost to Medicaid and additional health issues for both a mother and her baby.
- The Department's proposal would create a medical home to coordinate care with the goal of improving health outcomes.
- Focused on a specific population or condition, medical homes provide coordination of care to meet the health needs of the individual. In addition, medical homes allow the Department to better monitor the quality of the care provided to ensure that the benefits and services provided meet the individual needs of the person.

Effect of this change:

- Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based system to one based on value and positive health outcomes.
- Medical homes allow for care coordination that is specific to an individual's needs. Under the Department's proposal, a mother and her baby will have an individual benefit plan to ensure that prenatal services are coordinated to improve the health outcomes of the mother and her baby.
- This proposal is part of the Department's overall goal of improving overall birth outcomes and lowering the incidence of infant mortality in the state.
- According to the Department's May 2011 report *Wisconsin Births and Infant Deaths 2009*:
  - 426 infants under the age of one year died in 2009. The 2009 infant mortality rate was 6.0 infant deaths per 1,000 live births, compared to 7.0 in 2008 and 6.7 in 1999. The 2006 U.S. infant mortality rate (the latest available) was 6.7 infant deaths per 1,000 live births.
  - Broken down by ethnicity, the black/African American infant mortality rate for 2009 was 14.3 deaths per 1,000 births to black/African American women, compared to 13.8 in 2008 and 14.9 in 1999. The 2009 white infant mortality rate was 4.9 deaths per 1,000 births to white women, compared to 5.9 in 2008 and 5.7 in 1999. The Hispanic/Latino infant mortality rate for 2009 was 5.5 deaths per 1,000 births to Hispanic/Latina women, compared to 7.0 in 2008 and 7.7 in 1999.
- The Department's proposed medical home for pregnant women is aimed at helping mother and baby have a healthy pregnancy and birth. This will help lower the incidence of infant mortality and build strong, healthy families.

2011-2013 MEDICAID EFFICIENCIES

Long-Term Care Pilot Program – Virtual PACE

Category:	Service Delivery Reform
Focus Area:	People with Medicaid and Medicare eligibility or "dual eligibles"
Projected Savings:	$3.4 million GPR savings
Proposed Implementation Date:	Launch pilots in four regions of the state on July 1, 2012
Implementation Mechanism:	Demonstration Project

Description:

In Wisconsin, roughly 120,000 Medicaid enrollees are also enrolled in Medicare and are known as "dual eligible" members. Currently, the members must navigate a fragmented health care system that limits coordination among health providers and increases costs. The Department is developing a new program, Virtual PACE, a coordinated care system, for Wisconsin's dual eligibles who wish to receive their services in community settings. This is accomplished by fully integrating Medicare and Medicaid services and funds.

- Under the current PACE structure, care must be provided in an adult day care setting, and only those over the age of 55 are eligible. The new Virtual PACE program will serve adults of all ages in more counties with greater flexibility in the location of where care is provided.

- The Virtual PACE program will serve approximately 20,000 frail elders and adults with physical or developmental disabilities who require a nursing home level of care, and are eligible for both Medicaid and Medicare. The existing Family Care Program coordinates members' primary and acute care providers, physician-provided services and inpatient mental health services. This new structure brings all health, including hospitalization, behavioral health, palliative care, and long-term care services together in a coordinated manner. This will remove barriers, reduce fragmentation, and produce better health and social outcomes for these members while reducing costs.

- Under Virtual PACE, the Department will propose to receive a Medicare payment from the federal government for each member. The Department will combine the federal Medicare payment with a Medicaid capitation payment to create a single, fully integrated capitation payment to a care coordinator (contracted entity) for the provision of preventive, primary, acute, behavioral health, and long-term care services.

Effect of this change:

- A large share of costs in Medicare and Medicaid are attributable to services for dual eligible people because of their complex primary, acute, behavioral health, palliative care and long-term care needs. The integration of these health and long-term care programs provides an opportunity for Wisconsin to address these inefficiencies in order to provide coordinated care that will improve people's health and long-term care outcomes. This will also achieve significant savings for Medicaid and the Medicare.

- The current separation of Medicare and Medicaid payment for services and the lack of access to coordination creates administrative barriers to the promise of full integration, which prevents the best possible member outcomes and limits the most cost-effective use of all funding resources.

- Virtual PACE is part of the Department's overall goal of ensuring that long-term care programs in Wisconsin meet the needs of the members they serve and are manageable and fiscally sustainable.
- The Department is seeking input of managed care organizations, HMOs, integrated health care systems, health care providers, Medicare and Medicaid members and their families and caregivers, and other stakeholders as we proceed in designing this program.

2011-2013 MEDICAID EFFICIENCIES

Medical Home for Individuals with HIV/AIDS

Category:	Service Delivery Reform
Focus Area:	Individuals with HIV/AIDS
Projected Savings:	$200,000 GPR
Proposed Implementation Date:	January 2012
Implementation Mechanism:	State Plan Amendment (SPA)

Description:

The Department will submit a state plan amendment to create a medical home for individuals with HIV and AIDS. The medical home will coordinate the individuals care to ensure cost effectiveness while improving the overall quality of care.

- 2009 Wisconsin Act 221 requires the Department to develop a proposal to increase Medicaid reimbursement to each provider that receives a grant under the statutory provision entitled "Mike Johnson Life Care and Early Intervention Services Grants" to certain qualified providers.
- Part of the requirement of 2009 Act 221 is the development of care coordination for people with HIV/AIDS.
- Because of the complexity of these medical conditions, the lack of care coordination can lead to poor health outcomes, resulting in an increased cost to Medicaid and additional physical and mental hardship for the individual.
- The Department's proposal would create a medical home to meet the Act's requirement for the Department to develop a plan to coordinate care.
- Focused on a specific population or condition, medical homes focus on coordinating care to meet the health needs of the individual. In addition, medical homes allow the Department to better monitor the quality of the care provided to ensure that the benefits and services provided meet the individual needs of the person.

Effect of this change:

- Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based system to one base on value and health outcomes.
- Medical homes allow for care coordination that is specific to an individual. Under the Department's proposal, individuals who have HIV/AIDS will have individual benefit plans to ensure that services and treatments are coordinated and aimed at improving the health outcome of the individual.

2011-2013 MEDICAID EFFICIENCIES

Medical Home for Individuals with a Mental Health Diagnosis

Category:	Service Delivery Reform
Focus Area:	Individuals with a Mental Health Diagnosis
Projected Savings:	$1.5 million GPR
Proposed Implementation Date:	January 2012
Implementation Mechanism:	Medical Home State Plan Amendment (SPA)

Description:

The Department will submit a state plan amendment to create a medical home for individuals with a mental health diagnosis. The medical home will coordinate the individuals care to ensure cost effectiveness while improving the overall quality of care.

- Since these individuals are in fee-for-service, their care is not coordinated or monitored. Because of the complexity of these individual's medical condition, the lack of coordination can lead to poor health outcomes, resulting in an increase cost to Medicaid and additional physical and mental hardship for the individual.
- The Department's proposal would create a medical home to coordinate care with the goal of improving health outcomes.
- Focused on a specific population or condition, medical homes focus on coordinating care to meet the health needs of the individual. In addition, medical homes allow the Department to better monitor the quality of the care provided to ensure that the benefits and services provided meet the individual needs of the person. Some proposed services to improve care are peer supports and care extenders such as pharmacists.

Effect of this change:

- Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based system to one base on value and health outcomes.
- Medical homes allow for care coordination that is specific to an individual. Under the Department's proposal, individuals who have mental health and chronic conditions will have individual benefit plans to ensure that both physical and mental treatments are coordinated and aimed at improving the health outcome of the individual.

2011-2013 MEDICAID EFFICIENCIES

Medical Home for Individuals Leaving the Criminal Justice System

Category:	Service Delivery Reform
Focus Area:	Individuals Leaving the Correctional System
Projected Savings:	$1.0 million GPR
Proposed Implementation Date:	July 1, 2012
Implementation Mechanism:	Medical Home State Plan Amendment (SPA)

Description:

The Department will study the feasibility of submitting a state plan amendment to create a medical home for individuals who are exiting the criminal justice system. The medical home will coordinate the individuals' care to ensure cost effectiveness while improving the overall quality of care.

- Many individuals leaving correctional facilities and mental health facilities have extensive medical and mental health needs. Since a portion of these individuals are in fee-for-service, their care is not coordinated or monitored. Because of the complexity of these individuals' medical condition, the lack of coordination can lead to poor health outcomes, resulting in an increased cost to Medicaid and additional physical and mental hardship for the individual.
- The Department's proposal would create a medical home to coordinate care with the goal of improving health outcomes.
- Focused on a specific population or condition, medical homes provide coordination of care to meet the health needs of the individual. In addition, medical homes allow the Department to better monitor the quality of the care provided to ensure that the benefits and services provided meet the individual needs of the person.

Effect of this change:

- Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based system to one base on value and health outcomes.
- Medical homes allow for care coordination that is specific to an individual. Under the Department's proposal, individuals who leave the criminal justice system and are eligible for Medicaid will have individual benefit plans to ensure that services and treatments are coordinated and aimed at improving the health outcomes of the individual.

2011-2013 MEDICAID EFFICIENCIES

Medical Home for Individuals with Two or More Chronic Conditions

Category:	Service Delivery Reform
Focus Area:	Individuals with Two or More Chronic Conditions
Projected Savings:	$1.5 million GPR
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	Medical Home State Plan Amendment (SPA)

Description:

The Department will submit a state plan amendment to create a medical home for individuals with two or more chronic conditions. The medical home will coordinate the individuals care to ensure cost effectiveness while improving the overall quality of care.

- Since these individuals are in fee-for-service, their care is not coordinated or monitored. Because of the complexity of these individual's medical condition, the lack of coordination can lead to poor health outcomes, resulting in an increase cost to Medicaid and additional physical and mental hardship for the individual.
- The Department's proposal would create a medical home to coordinate care with the goal of improving health outcomes.
- Focused on a specific population or condition, medical homes focus on coordinating care to meet the health needs of the individual. In addition, medical homes allow the Department to better monitor the quality of the care provided to ensure that the benefits and services provided meet the individual needs of the person. Some proposed services to improve care are peer supports and care extenders such as pharmacists.

Effect of this change:

- Medical homes are a key part of the Department's overall goal of changing Medicaid's service delivery and reimbursement structure from a volume based system to one base on value and health outcomes.
- Medical homes allow for care coordination that is specific to an individual. Under the Department's proposal, individuals who have mental health and chronic conditions will have individual benefit plans to ensure that both physical and mental treatments are coordinated and aimed at improving the health outcome of the individual.

2011-2013 MEDICAID EFFICIENCIES

Non-Emergency Medical Transportation Management System

Category:	Service Delivery Reform
Focus Area:	Medicaid and BadgerCare Plus members, non-emergency medical transportation providers (except members in Southeastern Wisconsin, Family Care members and members residing in nursing homes)
Projected Savings:	$2 million GPR
Proposed Implementation Date:	July 1, 2011
Implementation Requirements:	Request for Proposals

Description:

The Department of Health Services, on July 1, 2011, implemented a Transportation Manager for non-emergency medical transportation (NEMT). Currently more than 40 other states use some type of Medicaid transportation management system.

- Federal rules require that Medicaid members have access to necessary transportation both to and from Medicaid covered services.

- The Transportation Manager is responsible for providing transportation to all eligible members. Additionally, the Transportation Manager is also responsible for informing and educating members regarding the Medicaid transportation program; authorizing services; scheduling, assigning, and dispatching trips; establishing and maintaining a transportation database; maintaining a call center; and tracking and responding to complaints.

- Medicaid non-emergency medical transportation includes specialized medical vehicles (SMV), wheel-chair, ramp, or lift-equipped vehicles provided to members with physical or cognitive needs, and common carrier services such as public transportation, taxis, volunteer drivers, cars, or members driving themselves.

Effect of this change:

- Previously, 86 different entities manage Medicaid NEMT services in Wisconsin (72 counties, 7 tribes, and 7 HMOs in Milwaukee). This fragmentation of management resulted in significant program inefficiencies.

- Providing services through a Transportation Manager improves access through better coordination and flexibility. The Manager is required to guarantee access to transportation services throughout the state and for providing the most appropriate means of transportation for the member.

- Moving to a centralized Transportation Manager for non-emergency medical transportation via a statewide contract increases the level of federal match that the State can claim.

- The Transportation Manager is required to collect and report transportation data to the Department of Health Services so that analysis can be done on who is currently using services, where service gaps exist, what form of common carrier transportation is used most frequently, whether efficiencies in the Medicaid transportation system are being maximized, and also allows the Department to conduct regular fraud and abuse monitoring activities.

2011-2013 MEDICAID EFFICIENCIES

Non-Emergency Medical Transportation Management System- Southeast Wisconsin HMO Members

Category:	Service Delivery Reform
Focus Area:	Medicaid and BadgerCare Plus HMO members (except Family Care and Nursing Home members) in the following Wisconsin counties: Washington, Ozaukee, Milwaukee, Waukesha, Racine, Kenosha. Non-Emergency Medical Transportation Providers
Projected Savings:	$3 million GPR
Proposed Implementation Date:	July 1, 2012
Implementation Requirements:	Request for Proposals

Description:

The Department successfully implemented a Non-Emergency Medical Transportation Management System for Medicaid members statewide in July 1, 2011 and is seeking to expand this to Southeast Wisconsin.

- Federal rules require that Medicaid members have access to necessary transportation both to and from Medicaid covered services.
- Currently more than 40 other states use some type of Medicaid transportation management system.
- The Transportation Manager will be responsible for providing transportation to all eligible HMO Medicaid recipients (except Family Care and Nursing Home members) in the following counties within Wisconsin: Washington, Ozaukee, Milwaukee, Waukesha, Racine, Kenosha.
- Additionally, the Transportation Manager would be responsible for informing and educating members regarding the Medicaid transportation program; authorizing services; scheduling, assigning, and dispatching trips; establishing and maintaining a transportation database; maintaining a call center; and tracking and responding to complaints.
- Medicaid non-emergency medical transportation includes specialized medical vehicles (SMV), wheel-chair, ramp, or lift-equipped vehicles provided to members with physical or cognitive needs, and common carrier services such as public transportation, taxis, volunteer drivers, cars, or members driving themselves.

Effect of this change:

- Currently, NEMT for eligible HMO members is managed by a non-synchronized, largely self-regulated, multi-vendor (HMO) effort in the following counties within Wisconsin: Washington, Ozaukee, Milwaukee, Waukesha, Racine, Kenosha
- This fragmentation of management results in significant program inefficiencies.
- Streamlining the entry point for Medicaid and BadgerCare Plus HMO members' non-emergency medical transportation to a single point will increase efficiencies in terms of cost, uniform policies, and coordination.
- Providing services through a Transportation Manager improves access through better coordination and flexibility. The Manager would be required to guarantee access to transportation services throughout the six counties and for providing the most appropriate means of transportation for the member.
- Moving to a centralized Transportation Manager for non-emergency medical transportation increases the level of federal match that the State can claim.
- The Transportation Manager would be required to collect and report transportation data to the Department so that analysis can be done on who is currently using services, where service gaps exist, what form of common carrier transportation is used most frequently, whether efficiencies in the Medicaid transportation system are being maximized, and also allowing the Department to conduct regular fraud and abuse monitoring activities.

2011-2013 MEDICAID EFFICIENCIES

Alternative Benchmark Plan

Category:	Benefit Reform
Focus Area:	BadgerCare Plus
Projected Savings:	$10.0 million GPR
Proposed Implementation Date:	January 1, 2012
Implementation Mechanism:	State Plan Amendment (SPA) Section 1937

Description:

The Department will enroll children and adults with income above 100% of FPL into the BadgerCare Plus Benchmark benefit plan. This initiative is part of the Department's overall efforts to bring Medicaid benefits in line with those in the private sector.

- Currently, the state enrolls approximately 17,000 individuals into a Benchmark plan that was designed based on coverage provided under the largest commercial HMO in the state.
- However, individuals enrolled in the BadgerCare Plus Standard plan receive a more generous benefit package with nominal cost to the individual.
- Compared to coverage offered in the private sector, the BadgerCare Plus Standard plan is a far richer benefit than those offered by many in the private sector.
- Key components of the new BadgerCare Plus alternative plan are:
  - Benefits under the new Benchmark plan would be similar to those in the commercial health insurance market.
  - Individuals under 150% FPL would have cost sharing capped at 5% of household income.
  - All non-pregnant individuals above 100% FPL would be enrolled in the Benchmark plan.
  - Children enrolled in the Benchmark plan would continue to have Early Periodic Screening, Diagnosis, and Treatment (EPSDT) coverage.
  - Children will be in the same coverage as their parents.

Effect of this change:

- The current benefit structure of BadgerCare Plus gives families a better benefit than what is found in the commercial insurance market and is not available to other families enrolled in Medicaid.
- This inequity provides an incentive for individuals and families to not increase their family income. The current system forces families to balance extra hours, increased wages or even promotion against BadgerCare eligibility. By simply bringing BadgerCare Plus in line with the private sector, overtime, wages and promotions will be viewed not as means of losing BadgerCare eligibility, but as tools to improve the lives of their families.
- This proposal brings government and private sector benefits more in line with each other, and creates an incentive for families to move from government health care back into the private, commercial health insurance market.
- With these changes, BadgerCare plus benefits will see similar changes that are common in private sector and government employee benefit packages.
- As a point of comparison, changes to state employee health insurance increased premium contribution to 12% of premium, and benefit package changes create an out of pocket maximum of $500 for an individual and $1000 for a family.

2011-2013 MEDICAID EFFICIENCIES

Maximize Drug Rebate Collections

Category:	Benefit Reform
Focus Area:	All Medicaid Populations
Projected Savings:	$3.0 million GPR
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	Medicaid Systems Changes

Description:

The Department will implement system changes to maximize pharmaceutical rebate opportunities for the Medicaid program.

- Medicaid programs must provide coverage and reimbursement for drug products manufactured by approximately 580 pharmaceutical companies that have entered into a federal rebate agreement with the Centers for Medicare and Medicaid Services (CMS).
- Wisconsin Medicaid is implementing policy changes to maximize drug rebate revenue collections from pharmaceutical companies.
- Wisconsin is implementing system modifications to ensure we collect rebates for all drugs administered in physician's offices. Federal law (2005 DRA) required state Medicaid programs to claim rebates on the top 20 physician-administered drugs. Wisconsin will move beyond the top 20 physician-administered drugs to pursue additional rebate dollars for the Medicaid program.
- Drug manufacturers will now pay states rebates for drugs dispensed to Medicaid members who receive their drug benefit through managed care organizations.
- In Wisconsin, while most drugs are provided on a fee-for-service basis, drugs are administered by managed care organizations for the PACE/Partnership programs. Wisconsin will collect drug rebates for enrollees in the PACE/Partnership program which are specialized long term care managed care organizations that serve persons who are in Medicaid and Medicare and Medicare Advantage plans.
- Wisconsin will obtain higher rebate amounts through competitive preferred product pricing from selected manufacturers in our diabetic supply program.

Effect of this change:

- These changes do not impact provider reimbursement or access to drugs by members.
- These changes ensure Wisconsin is collecting dollars from pharmaceutical manufacturers as allowed by federal law. Wisconsin will collect rebate dollars for any drug that is covered by the federal drug rebate program.
- Drug rebates are important contributions by pharmaceutical companies to ensure that Medicaid programs are able to offer these drug products to its members while maintaining financially solvent programs.

2011-2013 MEDICAID EFFICIENCIES

Wisconsin Pharmacy Quality Collaborative (WPQC) Participation

Category:	Benefit Reform
Focus Area:	All Medicaid Populations
Projected Savings:	$1.0 million GPR
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	Medicaid Systems Changes

Description:

The Department will participate in the Wisconsin Pharmacy Quality Collaborative (WPQC) with the goal of increasing the number of pharmacists who provide medication therapy management services to Medicaid members.

- Currently, pharmacies are reimbursed for the acquisition cost of the medication plus a dispensing fee.
- This reimbursement system is based on an old model of care delivery, where providers are reimbursed on the number of services provided, not on the quality of services offered and the health outcomes of these services.
- Working with stakeholders, the Department is working to reform Medicaid benefit delivery and provider payment into new systems based on quality outcomes and value, not volume.
- Medication therapy management (MTM) creates a partnership between pharmacist, patient and physician to better coordinate the delivery of medications. Instead of looking at each prescription independently, MTM looks at all of the medications an individual is taking and works to ensure they are achieving the desired outcomes, not counteracting each other and leading to poor outcomes.
- As a member of the WPQC, the Department is working to expand the number of pharmacies who are part of this effort. This will broaden and increase the Department's efforts aimed at improving health care outcomes while increasing the coordination of health care benefits.

Effect of this change:

- The Department's plan to participate in the WPQC is part of a larger pharmacy reform effort to improve health care outcomes while saving money by coordinating prescription care, limiting unnecessary or duplicative medications, and improving patient compliance.
- The Department is working with stakeholders to expand the use of medication therapy management to coordinate patients' medications. This is part of the Department's overall efforts to expand the use of care coordination to improve overall health outcomes.
- This effort is also part of the Department's overall goal of increasing the supply of health care providers by expanding the use of current providers and providing incentives for them to be "Care Extenders."

2011-2013 MEDICAID EFFICIENCIES

Asset Test Enhancement

Category:	Eligibility Reform
Focus Area:	Medicaid
Projected Savings:	$3.0 million GPR
Proposed Implementation Date:	Spring 2012
Implementation Mechanism:	System Modifications and Statutory Change

Description:

The Department will contract with a third-party vendor to obtain additional financial data to more accurately determine eligibility for Medicaid.

- Currently, individuals who are elderly, blind or disabled and are applying for Medicaid must meet an asset test where they are required to disclose all of their assets.
- The Department currently verifies self-disclosed assets through paper documentation provided by the applicant. The Department lacks the data and technology to cross-check for any un-disclosed assets electronically, making it possible for assets to be sheltered in order to gain eligibility for Medicaid.
- Through the use of a third party vendor, the Department will have access to more comprehensive financial data on people applying to Medicaid. This allows the Department to not only determine if the self-disclosure was correct, but to also determine the value of an individual's assets.
- In addition, the Department will work with Wisconsin financial institutions to provide additional data to improve eligibility determination accuracy.
- The Department is working with stakeholders to ensure the privacy of the data. As with all program application information, the Department will strictly adhere to confidentiality regulations.

Effect of this change:

- The Medicaid program is designed to provide health care and long-term care services to those who are in financial need.
- Unfortunately, some estate planners have created a "cottage industry" aimed at sheltering assets and income resulting in individuals gaining Medicaid eligibility despite having personal resources that should be used to pay for their own long-term care needs.
- Because of the ever changing world of personal finances, new and creative means of divesting income are constantly being developed. It is imperative for the state, and state taxpayers, that the Medicaid program has the tools and technology to identify sheltered assets and divestment activity.
- This provision, working in tandem with divestment reforms, will bring a new level of financial integrity to the program, and increase the Department's overall efforts to identify and prevent Medicaid fraud.

2011-2013 MEDICAID EFFICIENCIES

Divestment Policy Reforms

Category:	Eligibility Reform
Focus Area:	Long-Term Care
Projected Savings:	$2.7 million GPR
Proposed Implementation Date:	January, 2012
Implementation Mechanism:	Medicaid System Changes and Administrative Rulemaking

Description:

The Department will implement a series of systems and policy changes to prevent individuals from divesting assets in order to qualify for Medicaid.

- Divestment is the transfer of income, non-exempt assets and homestead property for less than fair market value. Divestment can affect the eligibility for Long-Term Care Medicaid.
- Certain exceptions to the divestment law allow an individual to transfer assets, typically to a family member, in order to qualify for long-term care services under Medicaid.
- Currently, federal law requires that the states implement policies aimed at preventing the divestment of assets in order to become eligible for Medicaid.
- Wisconsin's divestment policy was updated effective January 2009 to incorporate the changes outlined in the Deficit Reduction Act but there continue to be numerous 'loopholes' that leave the state at risk for people intentionally divesting their personal assets so their health care and long-term care is paid for through taxpayer dollars, rather than their own resources.
- Individuals should use their own resources before asking their neighbors to fund their long-term care needs.
- The following changes to the state's Medicaid program will tighten divestment policy and limit eligibility to those who truly need financial assistance for their health care and long-term care needs:

    - **Partial Refund Discontinuation** – This item would bring the state in line with divestment law by requiring individuals to fully refund all assets that have been divested before the Department would grant a reduced divestment penalty. Currently, when an individual intentionally divests their assets, a penalty period is imposed on the individual. If part of those assets are returned to the individual, current practice allows for a reduction in the penalty period based on the amount of assets that have been returned. Because of the way the penalty period runs, this process has created an opportunity for an individual to retrieve half of his or her divested assets and only receive half of the penalty. The end result is the successful sheltering of half of someone's assets, while he or she becomes eligible for Medicaid. Under this reform, the state would require individuals to fully return all assets that have been divested, before the Department would reduce the divestment penalty, eliminating a current loophole from the program.

    - **Revision of Penalty Start Date** – This item would allow the state to align a penalty period date with the recipient notice date. Currently, when a person already eligible for Long-Term Care Medicaid divests assets, a penalty period begins on the first day of the month the divestment occurred. However, a timely notice is required to terminate Medicaid eligibility so the person remains eligible until notice can be given. This means the person is not ineligible for Long-Term Care Medicaid for the entire penalty period. Doing so would mean that the entire penalty period will effectively be served by all Medicaid recipients who divest their assets while on Medicaid.

- **Mandatory Community Spouse Participation** – This item allows the state to deny eligibility when a community spouse refuses to participate and provide information on a Medicaid application for his or her spouse who is receiving institutional care. Spousal impoverishment laws use the resources of both the institutionalized spouse and community spouse to determine eligibility. When a community spouse refuses to provide information about his or her resources it allows those resources to be sheltered which means that Medicaid may end up paying for the cost of the spouse in the institution when it should not. Currently if there is non-cooperation the Department tests eligibility as if it were not a spousal impoverishment application for benefits. This policy was based on certain provisions of spousal impoverishment law and the right of the state to seek some support from the community spouse. However, a 2007 appellate court decision prohibiting such support actions now means that the law needs to be applied differently. Community spouses will now have to cooperate in order for the institutionalized spouse's eligibility to be determined. This policy will ensure that Medicaid truly is a safety net only for vulnerable people who do not have the means to provide care for themselves. The Department's proposal will bring the state more in line with federal requirements.

Effect of this change:

- The Medicaid program is designed to provide health care and long-term care services to those who are financially eligible.
- Unfortunately, some estate planners have created a "cottage industry" aimed at sheltering or using assets and income in ways for the individuals to gain Medicaid eligibility despite having personal resources to pay for their own long-term care needs.
- With the ever changing world of personal finances, new and creative means of divesting are constantly being developed. It is imperative for the state, and state taxpayers, that the Medicaid program has the tools and technology to identify divestment activity.
- This reform, working with improvements in asset verification, will bring a new level of program integrity to the program, and increase the Department's overall efforts to identify and prevent Medicaid fraud.

2011-2013 MEDICAID EFFICIENCIES

Eligibility Determination Integrity

Category:	Eligibility Reform
Focus Area:	Medicaid
Projected Savings:	$2.0 million GPR
Proposed Implementation Date:	Fall 2011
Implementation Mechanism:	Medicaid System Changes

Description:

The Department will implement a series of system changes to increase efficiency and effectiveness of the Medicaid eligibility system.

- Currently, the Department utilizes a number of information sources to determine eligibility for Medicaid.
- Medicaid members have a responsibility to report any changes that might impact their eligibility for Medicaid, including increases in income or obtaining health insurance in the commercial insurance market.
- If a person does not voluntarily report the change, the state's current system maintains an individual's Medicaid eligibility despite the person no longer being eligible for Medicaid.
- The Department proposes using several data sources to proactively search for changes in a member's income or health insurance status.
- By updating the state's ability to cross-check for eligibility, the Department will be able to terminate eligibility in "real-time" to people no longer Medicaid eligible.
- This change will reduce the state's exposure for risk in having non-eligible people remaining on Medicaid and is part of the Department's overall goal of determining Medicaid eligibility in real-time.

Effect of this change:

- New technologies provide the Department with opportunities to improve the process of determining initial Medicaid eligibility. This is an important step in moving the state toward a real-time eligibility system.
- These same tools are needed to ensure that people who have been determined eligible for Medicaid in fact remain eligible.
- The current system relies heavily on self-reporting. While this will remain a key component of the Department's eligibility efforts, the ability to cross-check with additional data resources will bring a new level of integrity to the Department's eligibility efforts.
- The Department's proposed system changes are an enhancement of the current eligibility process.

2011-2013 MEDICAID EFFICIENCIES

Maintenance of Effort (MOE) Waiver Request of Eligibility Restrictions Established Under the Patient Protection and Affordable Care Act (PPACA)

Category:	Eligibility Reform
Focus Area:	BadgerCare Plus, Medicaid
Projected Savings:	$54.4 million GPR
Proposed Implementation Date:	July 1, 2012
Implementation Requirements:	2011-13 State Budget, Section 1115 Demonstration Project

Description:

As required by the 2011-13 state budget, the Department will submit a proposed Demonstration Project under section 1115 to waive the Maintenance of Effort (MOE) Waiver requirements established under the Patient Protection and Affordable Care Act (PPACA). As outlined in the state budget, if the Department does not receive approval of the waiver request before December 31, 2011, the Department is required to reduce income eligibility for non-disabled, non-pregnant adults to 133% of the Federal Poverty Level (FPL), as allowed under federal law. Based on August 2011 caseloads, PPACA authorizes the state to dis-enroll 53,161 individuals (47,125 BadgerCare Plus parents and 6,036 BadgerCare Plus Core enrollees).

- First, as part of the American Reinvestment and Recovery Act (ARRA) and then PPACA, states are prohibited from making changes to eligibility standards, methodologies or procedures that are more restrictive than the standards, methodologies or procedures that were in place on March 23, 2010 (enactment date of PPACA).

- The PPACA does allow states who are in an economic emergency to unilaterally lower eligibility for non-disabled, non-pregnant adults to 133% FPL.

- While the state does have this option, the budget directs the Department to request a waiver of the MOE requirements to implement a series of eligibility changes in order to avoid making these federally allowed reductions.

- A key theme of the MOE waiver is re-establishing Medicaid as a safety-net for those low-income families who do not have access to private health insurance offered through employers and the individual market.

- The individual components of the MOE waiver are as follows:

    - **Eligibility Standardization** – This item would allow the state to restrict eligibility for Medicaid for people under the following scenarios:
        - Individuals/families are not eligible if they have access to employer-based health insurance and the employee contribution of the premium is less than 9.5% of household income.
        - Individuals/families are not eligible if they are currently covered under an major insurance policy when the household contribution to the premium is less than 9.5% of

household income.
- The PPACA establishes the definition of affordable health care to be 9.5% of household income. This provision would mirror the definition found in PPACA and allow the state to use it in determining eligibility for Medicaid.

- **Failure to Pay Reforms** – This item would allow the state to restrict eligibility to Medicaid for twelve months for anyone who refuses to pay a BadgerCare Plus premium or who has been terminated from the program for failure to pay a premium.

- **Income Determination Update** – This item would allow the state to include the income of all adults living in the same household, except grandparents, in determining Medicaid eligibility. The current income determination does not properly reflect the composition of today's households and will ensure that the true composition of the household income is used when determining eligibility.

- **Retroactive Eligibility** – This provision would allow the state to end the current practice of allowing people to receive BadgerCare Plus coverage for services provided up to three months before they applied for the program. This provision is a sharp contrast between the health insurance plans in the private sector and BadgerCare Plus. The elimination of this provision will bring equity to BadgerCare Plus and the private health insurance market.

- **Premium Reforms** – This item would allow the state flexibility to increase premiums up to 5% of family incomes for families with incomes above 150%. This reform will reduce the financial differences between government coverage and private coverage.

- **Presumptive Eligibility** - Wisconsin is one of a number of states with a robust online eligibility system, allowing people to enroll in Medicaid online. Using this existing system as a foundation, the Department is working to develop real-time eligibility, eliminating the need for presumptive eligibility. Presumptive eligibility is a relic of the arcane eligibility system that allows states to take up to 45 days to determine eligibility. This puts the state at risk of paying health claims on behalf of individuals not truly eligible for the program. When real-time eligibility is implemented, this item would allow the state to end the practice of presuming for up to three months that the person is eligible for Medicaid despite not fully completing the eligibility process.

- **Streamlined Eligibility Termination Process** – This provision would allow the state to terminate eligibility closer in time to the actual date of a recipient becoming ineligible. The current practice continues coverage until the end of the month in which eligibility is lost. It is a relic of older claims systems and can be modernized. Technology allows the state to take action sooner on terminated cases, resulting in cost savings and removal of disqualified people from the program.

- **Young Adult Eligibility Restrictions**– This provision will allow the state to require young adults between the ages of 19-26 to be covered under their parent's health insurance plan, not BadgerCare Plus. State and federal law changes have expanded mandates on private health insurers to cover adult children up to 26, greatly expanding access to coverage to young adults. Despite this change, current policy allows these individuals to gain coverage through Medicaid. By coordinating benefits, young adults can remain on their parent's health insurance, thereby increasing the number of healthy, low-risk individuals in private health insurance pools and lowering the numbers of people who depend on Medicaid.

- **State Residency Requirements** – This provision would allow the state to deny eligibility if an applicant or recipient fails to verify physical residence in Wisconsin. As a program supported with state and federal dollars, this provision ensures that Wisconsin taxpayers are supporting Wisconsin residents and not families living in neighboring states.

- **Transitional Medical Assistance (TMA) Discontinuation** – This provision would eliminate the

Transitional Medical Assistance group that was supposed to be a temporary program. Originally created as a one-time program, TMA allowed individuals previously on the cash-welfare system to increase their income above 100% of FPL and keep their MA benefits for up to one year. This was to help families transition off of the cash-welfare system into the new system (called Welfare to Work or W-2 in Wisconsin). Currently, the state allows Medicaid coverage to continue even if an individual's income increases to more than 200% of FPL. This system creates inequities in Medicaid eligibility. People, through TMA, have the ability to have incomes above 200% FPL and remain on Medicaid, while families who are not part of the TMA program are dropped from Medicaid when incomes rise above 200%. In addition to equity, this MOE proposal removes a disincentive to work by treating all income equally. Although the separate eligibility group is to be eliminated most individuals will still be eligible through other Medicaid plans.

Effect of this change:

- Wisconsin is one of a number of states struggling to balance its state budget. The impact of the recession, compounded with poor job and economic numbers in the past years, has forced states to tighten their belts and find efficiencies in their programs.

- A vital component for states in balancing their budgets is flexibility. However, the mandates under PPACA set arbitrary restrictions on how states manage their Medicaid programs. As a result, states are being forced to make reductions in other state programs to pay for the federal mandates imposed by PPACA.

- A key point is that these changes can be done while preserving the safety-net for those vulnerable Wisconsin residents and families who are in need of services. In fact, these reforms will stabilize Medicaid and ensure it is a viable service for those well into the future.

- These proposals are also focused on bringing equity between government paid health care programs and private health insurance. Policy decisions by states and the federal government have created a culture where family economic decisions are not based on what is best for their family's future, but what will keep them on government programs. This mentality is hindering our ability to grow jobs while expanding government spending.

- Many of these proposals are also aimed at making private insurance more affordable by expanding the number of healthy, low-risk individuals enrolled in private health insurance. Government policies aimed at bringing low-cost, low-risk individuals like children into government programs has created insurance pools that are older and sicker. Instead of having a strong cross-section of people purchasing health insurance, these private plans are forced to increase rates, making health insurance more expensive and making government's subsidized health plans a more attractive choice.

- Cost-sharing proposals, some of which are consistent with definitions within PPACA, will give families more incentive to remain in the private health insurance market. At that point, economic and career decisions can be focused on what is best for the future of the family, not what will keep me on a government program.

- Many of these reforms are also aimed at bringing Medicaid into the 21st century. Maintaining 17-year old eligibility standards based off of an eliminated program has created inequities in Medicaid eligibility. In addition, technology has given Wisconsin the ability to act quicker in eligibility determination. These provisions will save taxpayer resources while modernizing Medicaid for the future.